



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF HOME CARE AND REHABILITATIVE STANDARDS

LETTER OF INTENT FOR OPT's and/or CORF's

COMPLETE INFORMATION AND RETURN ALONG WITH POLICY MANUAL AND MEDICARE FORMS, IF APPLICABLE. MAIL TO: MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES, BUREAU OF HOME CARE AND REHABILITATIVE STANDARDS, P.O. BOX 570, 912 WILDWOOD DRIVE, JEFFERSON CITY, MO 65102.

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|------------------------------------|---------------|
| NAME OF AGENCY | TELEPHONE NO. |
| ADDRESS (STREET, CITY, STATE, ZIP) | COUNTY |
| CONTACT PERSON | |

TYPE OF AGENCY

☐ OUTPATIENT PHYSICAL THERAPY CLINIC ☐ COMPREHENSIVE OUTPATIENT REHABILITATIVE FACILITY

OWNERSHIP AND MANAGEMENT

| | | | |
|---|---|---|--|
| <input type="checkbox"/> Hospital Based <input type="checkbox"/> SNF/ICF Based Agency <input type="checkbox"/> Free Standing Agency <input type="checkbox"/> Other _____ _____ _____ _____ | Provider Base Entity: _____ _____ Address: _____ _____ _____ Provider Number: _____ Fiscal Year Ending Date: _____ | Non-Profit <input type="checkbox"/> Corporation <input type="checkbox"/> Other (Explain) _____ Proprietary <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation _____ | Government <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> City <input type="checkbox"/> City-County <input type="checkbox"/> District |
|---|---|---|--|

EXTENSION LOCATIONS:

LIST ADDRESSES, PHONE NUMBERS AND SITE COORDINATORS (ATTACHED ADDITIONAL SHEET IF NECESSARY)

SERVICES PROVIDED (Check all that apply)

☐ Speech Therapy ☐ Occupational Therapy ☐ Psychologist ☐ Other
☐ Physical Therapy ☐ Medical Social Services ☐ Rehabilitation Counselor _____

FOR OFFICE USE ONLY

Initial Forms Received

☐ 2572 ☐ 359 ☐ 1856 ☐ 855 Apprd: _____ ☐ FI Additional Info _____
☐ 1561 ☐ 690 ☐ 1513 ☐ SOS Registration ☐ FI Additional Info _____

☐ Fiscal Intermediary Preference Form

Assigned Surveyor _____ Policy Manual Received _____ Surveyor Checked Out Manual _____

Forms Sent to RO: _____

Permission Given to Agency to Start Caseload: _____ Confirmation Letter (90): _____

Federal Form Copies Sent to Medicaid/Medical Services: _____

Dates of Additional Contact: _____

Applicant Called Bureau - Ready For Survey: _____

Initial Survey Date: _____